DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2418 (Rev. 7-03)

STATE OF WISCONSIN

Check One
☐ **INITIAL** Application
☐ **RENEWAL** Application

ADULT DAY CARE CERTIFICATION APPLICATION

In accordance with 42 CFR 441.352(a)(1) and (2), adult day care centers, serving Medicaid waiver clients (COP-W, CIP I or CIP II), must meet State certification requirements established by the Division in order to receive funds for the cost of care for these participants. Completion of this form is required to become certified as an adult day care center. Failure to accurately complete and submit this form will result in denial of certification. Personal information collected on this form will be used for CERTIFICATION and for no other purpose. Send the completed form, with attachments listed below, to your Bureau of Quality Assurance Regional Office. Contact that office if you have questions about completion of this form.

PLEASE ATTACH THE FOLLOWING TO THIS APPLICATION

- List of staff and their title
- Diagram of floor plan of TOTAL space to be used by the center (indicate dimensions, exits and room usage)

NOTE: For RENEWAL, attach a revised floor plan if space or room usage has changed.

PLEASE CHECK ONE

☐ **CURRENTLY SERVE MEDICAID WAIVER CLIENTS**
Please list county agency providing funding, i.e., HSD, DSS, 51.42

☐ **ANTICIPATE SERVE MEDICAID WAIVER CLIENTS WITHIN THE NEXT 90 DAYS**

FACILITY NAME	Telephone Number
Facility Street Address	County
Facility Mailing Address (if different from street address, e.g., PO Box)	
City, State, Zip	

SPONSORING ORGANIZATION (if applicable)	Telephone Number
Address	
City, State Zip	

ADMINISTRATOR	Telephone Number
Address	
City, State, Zip	

CENTER DIRECTOR

DAYS of Operation

HOURS of Operation

TARGET POPULATION TO BE SERVED BY THE PROGRAM (e.g., elderly, developmentally disabled, etc.)

Anticipated number of clients to be served

Is adult day care provided in a nursing home? ☐ Yes ☐ No

Is adult day care provided in a community based residential facility (CBRF)? ☐ Yes ☐ No

Are any clients non-ambulatory? ☐ Yes ☐ No

Will meals be provided? ☐ Yes ☐ No

If yes, by whom?

The above information and all other statements and attachments are accurate to the best of my knowledge and I accept legal responsibility for complying with the laws, rules and regulations governing the certification of adult day care centers in Wisconsin. I authorize the Department to make such investigations as is necessary for verification of pertinent application information.

SIGNATURE - Applicant	Date Signed

Title